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## **Promoting health-enhancing physical activity in Europe: Current state of surveillance, policy development and implementation**

Breda, João ; Jakovljevic, Jelena ; Rathmes, Giulia ; Mendes, Romeu ; Fontaine, Olivier ; Hollmann, Susanne ; Rütten, Alfred ; Gelius, Peter ; Kahlmeier, Sonja ; Galea, Gauden

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# Promoting health-enhancing physical activity in Europe: Current state of surveillance, policy development and implementation

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## ABSTRACT

This study aims to present information on the surveillance, policy developments, and implementation of physical activity policies in the 28 European Union (EU) countries.

Data was collected on the implementation of the EU Recommendation on health-enhancing physical activity (HEPA) across sectors. In line with the monitoring framework proposed in the Recommendation, a questionnaire was designed to capture information on 23 physical activity indicators.

Of the 27 EU countries that responded to the survey, 22 have implemented actions on more than 10 indicators, four countries have implemented more than 20 indicators, and one country has fully addressed and implemented all of the 23 indicators of the monitoring framework.

The data collected under this HEPA monitoring framework provided, for the first time, an overview of the implementation of HEPA-related policies and actions at the national level throughout the EU. Areas that need more investment are the “Senior Citizens” sector followed by the “Work Environment”, and the “Environment, Urban Planning, and Public Safety” sectors. This information also enabled comparison of the state of play of HEPA policy implementation between EU Member States and facilitated the exchange of good practices.

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## 1. Introduction

Physical activity is at the core of health and well-being. The benefits of physical activity – including reduced risk of noncommunicable diseases and lower levels of stress, anxiety, and depression – are well known [1]. The World Health Organization (WHO) recommends that adults (including elderly) engage in at least 150 min of moderate-intensity aerobic physical activity each week [2]. Figures from European Union (EU) countries indicate that six in every 10 people above 15 years of age never or seldom exercise or play any sports, and more than half never or seldom engage in other kind of physical activity, such as cycling or walking, household chores

or gardening [3]. Another study confirms this trend pointing out that one third of adults in Europe are insufficiently active [4], in particular those from low socioeconomic backgrounds, minority ethnic groups, and people with disabilities [5]. Physical activity levels have declined among adolescents of 11–15 years of age, with girls being consistently less active than boys [6]. Only 34% of 13–15 year olds are active enough to meet the current WHO recommendation for children and adolescents, which is to maintain at least 60 min of moderate-to-vigorous physical activity every day [2]. Such physical inactivity contributes further to overweight and obesity, especially in young people from low socioeconomic backgrounds [7]. Research from the WHO European Childhood Obesity Surveillance Initiative shows that in some European countries more than 40% children are overweight and approximately 25% are obese [8]. This pattern also continues into adulthood, with current data indicating that more than 50% of adults are overweight in the

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majority of European countries [9], thus further contributing to the proliferation of noncommunicable diseases [5].

To address the problem of physical inactivity, many governments of the 28 EU countries have started to act in the last few years, by adopting policies that promote health-enhancing physical activity (HEPA) [10]. Nonetheless, as high levels of insufficient physical activity show no sign of decline in the population, there is a clear need for governments to do more. EU Member States, meeting in the Council of the EU, acknowledged the benefits of action at EU level, leading to the adoption of the Council of the EU Recommendation on promoting HEPA across sectors in 2013 [11]. The Council's aim was to encourage Member States to develop a cross-sectoral approach involving policy areas such as sport, health, education, environment and transport in their national strategies and action plans. In September 2015, ministers of the 53 Member States of the WHO European Region adopted the first ever Physical Activity Strategy for the European Region 2016–2025 [12]. The strategy focuses on all forms of physical activity promotion throughout the life-course in order to address the burden of noncommunicable diseases associated with insufficient activity levels and sedentary behaviour, thus enabling all citizens to live healthier and longer lives.

In the Recommendation, the Council of the EU recognized that more data with reliable and timely information on the situation across Member States was instrumental to support national and regional policy-making. To address this need, the Council of the EU proposed a monitoring framework based on the EU Physical Activity guidelines [13], which contained 23 indicators covering different themes relevant for HEPA (referred to hereafter as the HEPA monitoring framework).

The aim of this paper is to present the findings from the first round of reporting on the HEPA monitoring framework. This information represents a basis for comparison of country-specific data collected on HEPA policy developments across sectors in EU Member States.

## 2. Materials and methods

The Council of the EU Recommendation called on each EU Member State to appoint a national HEPA focal point, in accordance with national legislation and practice. All 28 EU Member States designated their focal points by mid-2014 and the network of national HEPA focal points was launched in Rome in October 2014. Its main role, in line with the Recommendation, was to coordinate the national collection of information for the monitoring framework.

A survey tool was developed to explore national actions by Member States and describe their capacity in various sectors, as set out in the 23 specific indicators of the HEPA monitoring framework. An indicator was considered implemented when a Member State had introduced a policy or programme as described by this indicator, although information about the specific policies within each indicator was also provided. The survey also included the option to mention if an indicator implementation is being prepared and is foreseen in the next two years.

Detailed information on definitions, operationalization, and data sources for the indicators can be found in the European Commission's working document [14].

The survey was piloted between October 2014 and January 2015, and based on an initial subset of eight indicators. A revised questionnaire was sent out in April 2015 and the contact persons in each country were asked to submit information on all 23 indicators to the WHO Regional Office for Europe by the end of June 2015. Upon receipt, information was checked for completeness and clarification in order to improve the quality of the data. To enable validation, the policy documents cited were reviewed to identify

whether they had been adopted and endorsed by the government and whether clear objectives and policy actions were described. Data was assessed to evaluate the overall situation and the extent of the implementation of HEPA promotion policies.

### 2.1. Monitoring framework

The monitoring framework [14] is composed of 23 indicators relating to the following key themes of the Council of the EU Recommendation: international physical activity recommendations and guidelines; cross-sectoral approach; sport; health; education; environment, urban planning, and public safety; working environment, senior citizens, indicators evaluation; and public awareness (Table 1).

### 2.2. International physical activity recommendations and guidelines – indicators 1, 2 and 3

The survey asked whether or not officially adopted national recommendation on physical activity levels exists. If so, in which international recommendation(s) [2,13,15–17] (if any) are they based, and which population group(s) do they target (i.e. children, adolescents, adults, or older adults).

It was also asked if there was knowledge of the physical activity population levels and to report the prevalence of adults, and children and adolescents reaching the minimum levels of physical activity recommended by WHO [2].

Countries reported the instruments, methodologies, sources, and surveys that supported this data.

### 2.3. Cross-sectoral approach – indicators 4 and 5

The analysis assessed the implementation of a national specific coordination mechanism (e.g. working group, advisory board, coordinating institution, etc.) for HEPA promotion and leadership of such mechanisms. It also included the assessment of funding allocated specifically to HEPA promotion.

### 2.4. Sport – indicators 6, 7, 8 and 9

Information on HEPA policies adopted on Sport sector was collected.

*Sport for All* refers the systematic provision of opportunities for physical activity accessible for everybody, rather than mainly favouring elite athletes. Countries were asked whether a *Sport for All* policy and/or action plan exists; if so, whether it is a dedicated national *Sport for All* policy that deals exclusively with the issue, or if it was a part of a broader national policy. The survey also explored target groups addressed by the national HEPA policy, implementation of *Sport Clubs for Health* programmes, and the arrangements made for increasing access to exercise facilities for socially disadvantaged groups.

### 2.5. Health – indicators 10, 11 and 12

Information on the existence of a national health monitoring and surveillance system with population-based measures of physical activity was also collected. Such information is important for tracking trends and changes in physical activity levels over time. This is critical for developing or improving national policies on physical activity.

Information about population-based measures of physical activity used in the health surveillance systems was asked.

The survey also assessed the existence of programmes or schemes to promote counselling on physical activity by health pro-

**Table 1**

The 23 indicators of the HEPA monitoring framework.

Thematic areas	Indicators	
International PA recommendations and guidelines	Indicator 1	National recommendation on physical activity for health
	Indicator 2	Adults reaching the minimum WHO recommendation on physical activity for health
	Indicator 3	Children and adolescents reaching the minimum WHO recommendation on physical activity for health
Cross-sectoral approach	Indicator 4	National government coordination mechanism and leadership on HEPA promotion
	Indicator 5	Funding allocated specifically to HEPA promotion
Sport	Indicator 6	National <i>Sport for All</i> policy or action plan
	Indicator 7	<i>Sport Clubs for Health</i> Programme
	Indicator 8	Framework to support offers to increase access to exercise facilities for socially disadvantaged groups
	Indicator 9	Target groups addressed by the national HEPA policy
Health	Indicator 10	Monitoring and surveillance of physical activity
	Indicator 11	Counselling on physical activity
	Indicator 12	Training on physical activity in the curriculum of health professionals
Education	Indicator 13	Physical education in primary and secondary schools
	Indicator 14	Schemes for school-related physical activity promotion
	Indicator 15	HEPA in training of physical education teachers
	Indicator 16	Schemes promoting active travel to school
Environment, urban planning, and public safety	Indicator 17	Level of cycling and walking
	Indicator 18	European guidelines for improving infrastructure for leisure-time physical activity
Working environment	Indicator 19	Schemes to promote active travel to work
	Indicator 20	Schemes to promote physical activity at the workplace
Senior citizens	Indicator 21	Schemes for community interventions to promote physical activity in older adults
Indicators evaluation	Indicator 22	National HEPA policies that include a plan for evaluation
Public awareness	Indicator 23	National awareness raising campaign on physical activity

PA: physical activity; WHO: World Health organization; HEPA: health-enhancing physical activity.

professionals, as well as physical activity training in the curriculum of health professionals.

## 2.6. Education – indicators 13, 14, 15 and 16

Information on HEPA policies adopted on Education sector was collected.

Respondents were asked to provide information on the number of hours of mandatory and optional physical education classes in primary and secondary schools.

The existence of national schemes for active school breaks (i.e. breaks between school lessons), for active breaks during school lessons, for after-school HEPA promotion programmes, and to promote active travel to school was assessed.

A question about whether or not HEPA was included in the curriculum of Physical Education teachers, at the bachelor's and/or master's degree level, was also asked.

## 2.7. Environment, urban planning and public safety – indicators 17 and 18

Several questions were asked about the various modes of transportation for daily activities. This included monitoring cycling and walking time and/or distance per day for all travel purposes. The existence of policies to promote active transport and the use of the Health Economic Assessment Tool (HEAT) for Walking and Cycling [18] from WHO was also asked.

Furthermore there was also a question on the application of the European Guidelines for Improving Infrastructures for Leisure-Time Physical Activity in the Local Arena [19] on planning, building and managing infrastructures.

## 2.8. Working environment – indicators 19 and 20

The survey asked whether there exists a national scheme to promote active travel to/from work, and incentive schemes for companies to promote physical activity at the workplace.

## 2.9. Senior citizens – indicator 21

Given that most EU Member States have ageing populations, and remaining physically active is important for the health of older people [20–22], countries were asked for information on schemes for community interventions to promote physical activity in this age group.

## 2.10. Indicators evaluation – indicator 22

A question about if the national HEPA policies include an evaluation plan was a part of the survey.

## 2.11. Public awareness – indicator 23

The survey concluded by collecting information on the existence of national awareness raising campaigns, including whether there was a specific focus on issues such as motivation, behavioural change or cultural acceptability.

# 3. Results

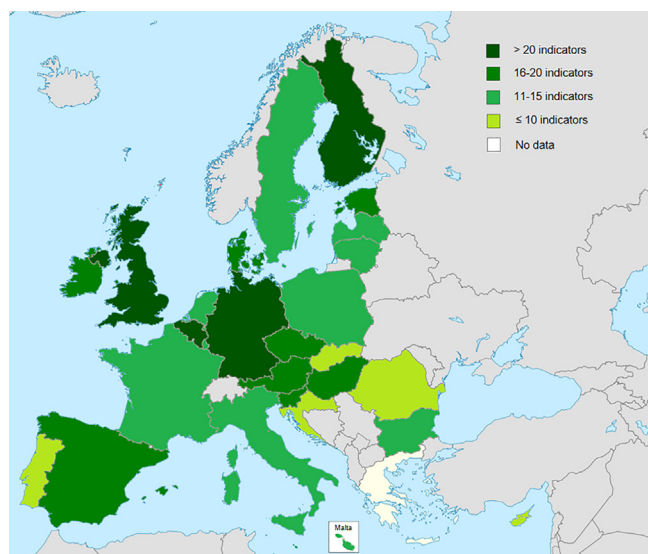
In this first round of data collection under the HEPA monitoring framework, 27 of the 28 EU countries (Greece did not take part in the survey) answered the survey on the implementation of the 23 indicators. This data present a good overview of the state of play of HEPA promotion in the European Union (Table 2). Detailed national data and information can be found in separate country factsheets published by the WHO's Regional Office for Europe and the European Commission [23].

Of the 23 indicators of the monitoring framework, 22 countries (81.5%) have implemented more than 10 indicators, while four countries (14.8%) have implemented more than 20 indicators (Fig. 1). Only one country (3.7%) fully addressed and implemented all 23 indicators of the monitoring framework (Table 2).

**Table 2**  
Implementation of HEPA policies in line with the 23 indicators in 27 EU Member States.

Indicators	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	Total
AUT	I	I	I	0	0	I	0	0	I	F	I	I	I	0	I	I	0	I	I	I	I	I	I	16
BEL	I	I	I	I	I	I	F	I	I	I	I	I	I	I	I	I	I	F	I	I	I	I	I	21
BUL	F	I	I	F	I	I	I	0	I	F	F	F	I	I	0	F	I	F	F	F	F	I	I	11
CRO	F	I	I	F	I	I	0	0	I	0	I	0	I	I	0	0	0	0	0	F	0	I	F	9
CYP	F	I	0	F	0	I	0	0	I	0	0	0	I	0	I	0	0	0	0	0	0	I	0	6
CZH	F	I	I	I	I	I	I	F	I	I	F	I	I	I	I	I	0	F	I	F	I	I	0	16
DEN	I	I	I	0	I	I	0	I	I	I	F	I	I	I	I	I	I	0	I	I	0	I	I	18
DEU	I	I	I	I	I	I	I	I	I	I	I	I	I	0	I	0	I	I	I	I	I	I	I	21
EST	I	I	I	I	I	I	0	0	I	I	F	I	I	F	I	0	I	I	0	F	I	I	I	16
FIN	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	23
FRA	I	I	I	I	I	I	F	F	I	F	I	I	I	0	0	0	I	F	I	0	0	I	I	14
HUN	I	I	I	I	I	I	0	I	I	F	I	I	I	I	I	I	I	0	I	I	I	I	I	20
IRE	I	I	I	I	I	I	I	I	I	I	F	F	I	I	I	I	I	0	I	I	I	I	F	19
ITA	I	I	I	F	0	I	I	I	I	0	0	0	I	I	0	I	I	F	0	0	0	I	0	12
LVA	I	I	I	0	I	I	0	0	I	I	I	I	I	I	I	F	0	0	0	F	F	I	I	14
LTU	I	I	I	I	I	I	0	0	I	I	F	I	I	F	I	0	0	0	0	0	0	I	I	13
LUX	I	I	I	I	I	I	0	0	I	I	0	0	I	I	0	0	I	0	I	0	I	I	I	15
MAT	I	I	I	I	I	I	0	0	I	I	F	I	I	I	I	0	I	F	0	F	0	I	I	15
NET	I	I	I	0	I	I	0	I	I	0	I	I	I	0	0	0	I	0	I	I	0	I	0	14
POL	F	I	I	0	I	I	0	0	I	0	I	I	I	0	I	0	0	0	0	0	I	I	I	12
POR	F	I	I	I	I	I	0	0	I	F	0	0	I	0	0	0	0	0	0	0	0	I	0	8
ROM	0	I	I	I	0	I	0	0	I	0	F	I	I	F	I	0	0	0	0	0	0	I	I	10
SVK	0	I	I	0	0	I	0	0	I	0	I	0	I	0	I	0	0	0	I	0	0	I	0	9
SVN	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	F	0	0	I	I	I	I	I	20
SPA	I	I	I	I	0	I	0	0	I	I	I	0	I	I	I	0	I	0	0	I	I	I	I	16
SWE	I	I	I	0	I	I	0	0	I	I	I	0	I	0	I	0	I	0	0	I	0	I	0	13
UNK	I	I	I	I	I	I	0	I	I	I	I	I	I	I	I	I	I	0	I	I	I	I	I	21
Total	19	27	26	16	21	27	7	10	27	17	13	17	27	15	20	9	16	4	14	12	13	27	18	

I: implemented indicator; F: implementation foreseen; 0: indicator not implemented or question not answered. HEPA: health-enhancing physical activity; EU: European Union. Country codes are World Health Organization official.



**Fig. 1.** Number of implemented indicators across Health-Enhancing Physical Activity thematic areas by the European Union Member States.

Map Source: EuroGeographics. Note: The designations employed and the presentation of material on this map do not imply the expression of any opinion whatsoever on the part of the European Union concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

### 3.1. National recommendations for physical activity for health – indicator 1

National policy recommendations on physical activity for health have been established by 19 (70.4%) countries. Of these, 18 (66.7%) target adults, 17 (63.0%) target young people and 16 (59.3%) target older adults.

In 10 countries, the national recommendations were based on the WHO's recommendations alone [2], and one country's recommendations followed EU's physical activity guidelines [13]. Eight countries followed other international recommendations, such as those of the United States Department of Health and Human Services [15], Canadian guidelines [17], the American College of Sports Medicine and American Heart Association [16], or a combination of several international recommendations.

### 3.2. Physical activity levels – indicators 2 and 3

Several countries reported data on physical activity prevalence from more than one source and/or instrument (Table 3).

Twelve countries provided physical activity prevalence data for adults from their independent national studies. Data from international studies was also reported – six countries reported Eurobarometer [3] data and two countries used European Health Interview Survey [24] results as their national data on physical activity prevalence. In addition, one country also reported data from objective measurements of physical activity and used instruments such as accelerometers. In countries where no national studies were available, physical activity prevalence in adults was



**Table 3**

Variety of surveillance instruments used to collect prevalence data on physical activity among the countries of the European Union.

Instrument used	Number of countries
<i>Adults</i>	
Global Health Observatory	27
National survey	12
Eurobarometer	6
European Health Interview Survey	2
National studies using objective measurements	1
<i>Children and adolescents</i>	
Global Health Observatory	26
National survey	8
National studies using objective measurements	2
Health Behaviour in School-aged Children	17

Note: Some countries have reported using more than one instrument.

extracted from the WHO's Global Health Observatory (GHO) estimates, which was established to generate comparable data in multiple areas, including physical activity [25].

Numerous existing standardized instruments, to support the national monitoring of physical activity levels in adults, were used. Examples include the International Physical Activity Questionnaire (IPAQ) [26]; the Global Physical Activity Questionnaire (GPAQ) [27]; the European Commission's Eurobarometer [3]; or a national verified source (i.e. policy documents, or national recommendations, and national studies).

The reported prevalence data revealed big differences within countries, depending on the methodologies used. For example, one national survey reported a 34% prevalence of physical activity among adults 18–65 years of age, but another nationally representative study, based on objective measurements of physical activity, showed 24% of all adults (18–85 years of age) meeting current WHO recommendations. In another example, data from the national study indicated a 66% prevalence of physical activity among adults (18–69 years of age), while Eurobarometer data suggest that only 25% of adults in that country meet WHO recommended levels. Such examples highlight discrepancies in data due to a wide variety of instruments and methodologies used. This creates difficulties in establishing validity and comparability across the EU.

The GHO estimates for adults were much higher than prevalence levels reported in national studies or measured by other instruments. For example, in one country the GHO estimate was more than double that shown for the national study (74%), and in another the GHO estimate was 80% compared to 18% reported by the national study. Overall for the 28 EU Member States, GHO estimates indicated that adult men were slightly more active than women, with 59.7%–88% of adult males and 50.1%–82.1% of adult females meeting WHO recommended physical activity levels. As can be seen from the examples above, however, these values cannot be compared to the national studies.

There were also differences in instruments and surveys within countries regarding the data for children and adolescents (Table 3). Across the EU, eight countries reported data from their national surveys, and two countries extracted data using objective measurement techniques. In total, 17 countries reported data from Health Behaviour in School-aged Children (HBSC) [28] survey. For example, the national survey data in one country reported that 20% of adolescents (11–15 years old) reached the WHO recommended physical activity levels, but an objective measurement study reported that 50% of 7–12 years old in the country were meeting the WHO recommendation.

GHO estimates for adolescents were derived from HBSC data combined from more than one round of data collection, possibly explaining similar or slightly lower values when compared to data from national studies. For example, one national study

**Table 4**

Implementation of policies by sector and target groups addressed.

HEPA Sector	N.° of countries with one or more policy implemented
Sport	27
Health	23
Education	27
Environment, urban planning, and public safety	17
Working environment	16
Senior citizens	13

HEPA: health-enhancing physical activity

reported a physical activity prevalence of 29% among 11–15 year-olds, whereas the GHO value was 17%. In another example, national survey data revealed a prevalence of 28% for children and adolescents (3–18 years), and GHO estimates for the same country showed a prevalence of 17% for adolescents (11–15 years old). In the EU Member States for which GHO estimates for adolescents were available (no data was available for Cyprus), 9%–35.4% of boys and 7.4%–20.4% of girls, were meeting the WHO recommended level of physical activity [25].

Only one country reported no data from children and adolescents in the present study.

While all of the information provided is valuable by offering an overview of surveillance indicators in the countries, it is important to note that these national data do not allow for comparisons across countries due to sampling and other methodological differences.

### 3.3. Cross-sectoral approach – indicators 4 and 5

A total of 16 countries (59.3%) reported having a fully developed and implemented specific national coordinating mechanism (advisory body, coordinating institution, academia, working group, or community) on HEPA promotion. One country reported intense cross-ministry cooperation at the federal level, which had the effect of a coordinating mechanism, and four more countries envisaged introducing a mechanism within two years.

Twenty one countries (63.0%) reported having funding allocated specifically to HEPA promotion between 2013 and 2015.

### 3.4. HEPA policies in different sectors

All 27 respondent countries have developed national policies or action plans in one or more of the HEPA sectors covered by the questionnaire (Table 4).

It is noteworthy that in 2014 and 2015 – following adoption of the Council of the EU Recommendation in November 2013 – new policies were adopted in all the sectors in the Member States. More specifically, new policies in the sport sector were adopted in 13, health-related policies in 10, education-based policies in eight, environment-focused policies in three, and policies for senior citizens in three Member States.

### 3.5. National sport for all policy or action plan – indicator 6

Twenty-seven countries reported implementing *Sport for All* policies and/or action plans. In 22 countries (81.5%) these policies were exclusively dedicated to the issue at the national level.

### 3.6. Sport clubs for health programmes – indicator 7

*Sport Clubs for Health* programmes, which encourage sport clubs to invest in health-related sport activities and/or health promotion within sport activities [14], were implemented in seven countries (25.9%) with two more countries planning the implementation of the said programmes in the near future. The programmes were

supported by national associations/organizations that provided assistance in a variety of areas, such as: instructor training, project development and piloting, and sharing of best practices and materials.

### 3.7. Framework to support offers to increase access to exercise facilities for socially disadvantaged groups – indicator 8

Ten countries (37.0%) reported the implementation of specific frameworks to support access to recreational or exercise facilities for socially disadvantaged groups. Of these, eight had implemented programmes nationwide and two covered a number of municipalities (15 and 23, respectively). The programmes aimed to integrate immigrants or socially vulnerable groups by providing access to recreational facilities, as well as to help develop sustainable facilities and appropriate equipment to maximise participation in sports and physical recreation. Two Member States focused more on using sport as an integral component of rehabilitation and reintegration programmes for persons with disabilities [23].

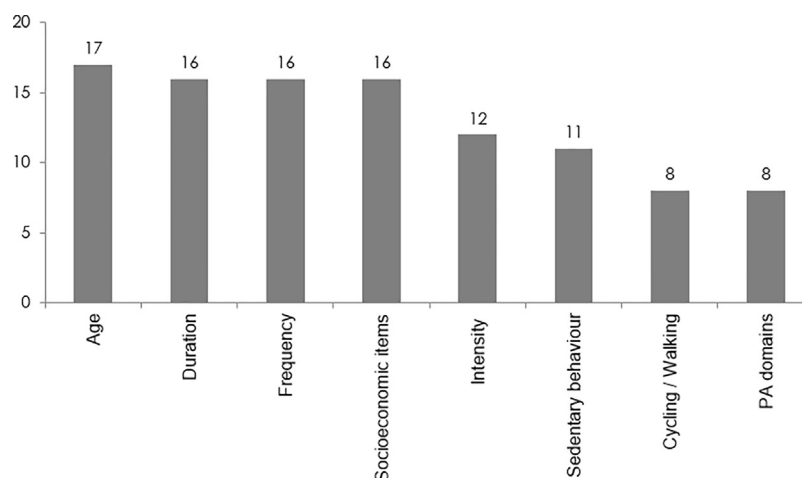
### 3.8. Target groups addressed by the national HEPA policy – indicator 9

There was considerable variation in the extent to which policies focused on different population groups (low socio-economic status groups; low levels physical activity; elderly; ethnic minorities; women before and during pregnancy; etc.). Some countries addressed the needs of more than one target group in an integrated way, while others addressed particular target groups depending on the HEPA sector (sport; health; education; environment, urban planning, and public safety; working environment; and senior citizens). All 27 countries addressed at least one group with particular need of physical activity in HEPA policies.

### 3.9. National health monitoring and surveillance system – indicator 10

Established health surveillance and monitoring systems, that include population-based measures of physical activity, were reported in 17 (63.0%) countries. Five countries (18.5%) envisaged implementation of these surveillance and monitoring systems within the next two years.

Fig. 2 illustrates which population-based measures are most commonly included in surveillance or health monitoring systems.



**Fig. 2.** Population-based measures of physical activity commonly included in surveillance or health monitoring systems. PA: physical activity. Note: 17 countries reported having a surveillance or health monitoring system for physical activity in place.

Age group, exercise duration, frequency of exercise, socioeconomic status, exercise intensity, sedentary behaviour, cycling/walking, and other domains of physical activity were most frequently measured.

In some countries, additional aspects were measured. For example: annual check-ups for sport professionals, children and adolescents with increased physical activity (engaged in extra-curricular sport activities); and physical functional capacity assessments, or measures intended to capture different dimensions of physical activity in leisure-time activities. In addition, one country reported the existence of an intervention database with an insight into quality, feasibility and effectiveness of various intervention undertakings [23].

### 3.10. Counseling on physical activity – indicator 11

Thirteen countries (48.1%) had programmes in place to promote physical activity counselling by health professionals. These programmes mostly related to the prevention of noncommunicable diseases and provided guidance to health professionals, sometimes in the form of free online courses.

### 3.11. Training on physical activity in the curriculum of health professionals – indicator 12

Training on physical activity was included in curriculum for health professionals in 17 countries (63%), with 14 countries (51.9%) providing training modules for medical doctors and physiotherapists, and eight (29.6%) providing training modules for nurses. There was considerable country variation in the structure and duration of the modules.

### 3.12. Physical education in primary and secondary schools – indicator 13

While all the respondents countries have put into action a number of mandatory physical education classes, six countries allowed for a combination of mandatory and optional physical education classes in primary schools, and five in secondary schools, respectively. Mandatory physical education hours varied from one to almost five hours per week, depending on the grade level and on the country or region.

### 3.13. Schemes for school-related physical activity promotion – indicator 14

Fifteen countries (55.60%) reported the implementation of at least one school-related HEPA promotion programme: active breaks between school lessons (eight countries, 29.6%), active breaks during school lessons (four countries, 14.8%) and extra-curricular activities (11 countries, 40.7%). Across these programmes, children were encouraged to participate in physical activities, with some countries focusing on disadvantaged children, or on children not otherwise interested in sports. They did this by providing equipment and inspiration to participate, or helping teachers to integrate movement into classes. Four countries (14.8%) focused more on extra-curricular sports.

### 3.14. HEPA in training of physical education teachers – indicator 15

HEPA was included in the training of physical education teachers in 20 countries (74.1%). Of those, 15 had mandatory modules in place, while no information was available for one country due to federal system regulations.

### 3.15. Schemes promoting active travel to school – indicator 16

To encourage active travel to school, nine countries (33.3%) reported implementing programmes, mostly through measures to make cycling and walking to school safer.

### 3.16. Level of cycling and walking – indicator 17

Walking and cycling are among the three main modes of transport in 20 (74.1%) and eight (29.6%) countries respectively.

Less than half of the countries (13, 48.1%) reported using their national survey to monitor time and/or distance walked or cycled per day for all travel purposes (school, work, or leisure). For example, in one country, walking and cycling accounted for 18% and 17% of trips taken in 2014, respectively. Five countries have used the HEAT [18] to estimate the potential health and economic benefits of a cycling and/or walking infrastructure policy. Another country reported using a tool similar to HEAT [23]. For example, it was reported that in one European capital, 45% of people who study or work use bicycles as the main mode of transport, predicting an estimated one million fewer sick days till 2020 in that city [23]. Furthermore, some countries have introduced creative tax incentives, including VAT refunds on bike purchases, tax exemption and/or employee compensation for walking or cycling to work, high parking fees, and/or congestion charges. Sixteen countries (59.3%) showed at least one policy in this area: presence of either a travel survey, the use of the HEAT tool, or tax incentives.

### 3.17. European guidelines for improving infrastructures for leisure-time physical activity – indicator 18

Four countries (14.8%) reported implementing the European Guidelines for Improving Infrastructures for Leisure-Time Physical Activity in the Local Arena [19] and six other countries had plans to do so in the near future.

### 3.18. Schemes to promote active travel to work and physical activity at the workplace – indicators 19 and 20

Fourteen countries (51.8%) reported implementing active travel to work schemes, while physical activity at the workplace was stimulated by schemes in place in 12 countries (44.4%).

### 3.19. Senior citizens – indicator 21

Schemes for community interventions to promote physical activity in senior citizens were reported in 13 countries (48.1%). Two countries reported plans to implement it in the near future. Programmes and strategies took various forms, including: provision of organised HEPA programmes for older adults in different environments in cooperation with local communities (in eight countries); programmes for the enhancement of balance and coordination of older adults, including frailty and fall prevention (in three countries); education and exercise counselling (in three countries); and integration and availability of physical activity programmes for all, especially for socially disadvantaged people and older adults (in two countries).

### 3.20. HEPA policies evaluation plan – indicator 22

Of 152 policies or action plans addressing the above-mentioned HEPA sectors (sport; health; education; environment, urban planning, and public safety; working environment; and senior citizens), 116 (76.3%) contained an evaluation plan. Further investigation was not possible, however, because the question only addressed whether such a plan exists and did not contain further details on implementation. All 27 countries reported at least one evaluation plan on one of the HEPA sectors.

### 3.21. National awareness campaign on physical activity – indicator 23

National strategies usually include an awareness-raising campaign on physical activity. Successful implementation of communication campaigns to promote public awareness of physical activity was reported by 18 countries (66.7%). One country reported as many as 14 different campaigns, while another implemented nine separate campaigns [23]. The approach of the campaigns varied, and examples include: workshops; website monitoring; street culture integration with sports; and the designation of a specific day, week or year of sports. Despite using different strategies all of the campaigns aimed to increase the number of people who are physically active and to raise awareness of the benefits of physical activity. While some campaigns targeted all citizens, others were aimed at vulnerable groups, such as children or senior citizens. The outreach of the campaigns was sometimes nationwide, while at other times it was limited to a region or specific cities.

## 4. Discussion

The results presented in this report give a good overview of the state of play of HEPA policy implementation in EU Member States. This exercise was able to assess the extent to which Member States have implemented policies in different areas, to highlight examples of good practices and to pinpoint areas that need more development or improvement in order to achieve the third Sustainable Development Goal established by the United Nations (good health and well-being) and to minimize the prevalence of overweight and obesity [29].

Many challenges remain with regard to the comparability of the monitoring of HEPA policies and physical activity levels across EU Member States.

First, definitions of recommended levels of physical activity vary between countries. Second, different methods are used to collect data, which variates the results. For example, national physical activity surveys sometimes used non-standardized instruments or have switched from non-standardized to standardized instruments (such as IPAQ or GPAQ) leading to a loss of time-series of national data.



In addition, standardized instruments were not always used according to the adopted protocols, leading to a lack of comparability between surveys even though the same instruments had been used.

While discrepancies between GH0 prevalence estimates and results from other instruments were found, this is most likely due to the methodology for calculating the estimates. The GH0 estimates remain one of the most reliable and used tools available for inter-country comparison at this point in time.

It is notable that only a few countries have implemented policies covering all areas of the monitoring framework, indicating that there is clearly room for improvement across the EU.

Areas with less indicators accomplishment that need more investment are the “Senior Citizens” sector followed by the “Working Environment”, and the “Environment, Urban Planning, and Public Safety” sectors. Overall, indicators with less than 50% of accomplishment are indicators 7 (*Sport Clubs for Health Programme*), 8 (Framework to support offers to increase access to exercise facilities for socially disadvantaged groups), 11 (Counseling on physical activity), 16 (Schemes promoting active travel to school), 18 (European guidelines for improving infrastructures for leisure-time physical activity), 20 (Schemes to promote physical activity at the workplace) and 21 (Schemes for community interventions to promote physical activity in older adults). More policies on these indicators should be incentivized.

As Member States often provided references in their national languages, the language barrier made it challenging to verify some of the information. While the effectiveness of individual policies could not be measured, the adoption of policies could be verified.

Some countries also provided information on HEPA funding. However, because financial support for HEPA comes from different budgets at the national level, comprehensive reporting on this indicator was not possible at this stage.

Moreover, for some indicators the possibility of “false negative” replies (i.e. “no” actually meaning “no information available or sought” due to lack of the relevant network contacts or resources rather than “no scheme/data existing”) should also be further explored.

Finally, data was collected at the national level, but the monitoring exercise did not explore in detail any achievements at regional and local levels.

For future rounds of data collection, it will be essential to modify the survey instruments, e.g. by using an online tool, and to specify indicator definitions in more detail to reduce the margin for interpretation, and thereby, margin of error when recording the data. This would enable more streamlined data collection across EU countries, thus facilitating better inter-country data comparisons, which are much needed.

Furthermore, to increase the comparability of prevalence data over time, it would be beneficial to use the same instruments over time. As countries improve their national surveillance systems with more data, international comparisons will also improve.

Future data collection exercises under the HEPA monitoring framework could also consider exploring ways to better capture efforts at the regional and possibly even the local level.

The Council of the EU Recommendation and the WHO Physical activity strategy for the WHO European Region 2016–2025 appear to have provided a strong incentive for Member States to act. This first round of results from the monitoring framework shows the need to create HEPA coordination structures over the next few years. The data presented here should also be used as a basis for Member States to share their experiences, such as through the HEPA focal point network. This study highlights valuable examples of national successes and good practices, providing inspiration for

those countries that are in the process of developing or modifying their national strategies and policies.

## 5. Conclusion

The data collected under this HEPA monitoring framework provided, for the first time, an overview of the implementation of HEPA-related policies and actions at the national level throughout the EU. Areas that need more investment are the “Senior Citizens” sector followed by the “Working Environment”, and the “Environment, Urban Planning, and Public Safety” sectors. This information also enabled comparison of the state of play of HEPA policy implementation between EU Member States and facilitated the exchange of good practices.

## Conflict of interest

None declared.

## Disclaimer

JB and GG are WHO staff members. Views expressed here are their own.

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